OWNERSHIP AND CONVICTION DISCLOSURE

Please list the name and address of each person or corporation with a direct or indirect ownership or control interest of 5% or more in the provider or in any subcontractor in which the provider has direct or indirect ownership of 5% or more. (This applies to all providers other than an individual practitioner, a group of practitioners, or a fiscal agent.)

NAME	ADDRESS	% OF INTEREST
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are any of the above mentioned persons related to another as a spouse, parent, child, or sibling?
Yes _____ No _____ If yes, please name and show relationship.

NAMES	RELATIONSHIP
_____	_____
_____	_____
_____	_____

Do any of the persons or corporations with an ownership or control interest have an ownership or control interest of 5% or more in any other Medicaid provider? Yes ____ No ____ If yes, please name and show.

NAME	OTHER PROVIDER NAME	% OF INTEREST
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any person who has an ownership or control interest in the provider, or is an agent managing employee of the provider who has ever been convicted of a felony:

NAME	
_____	_____
_____	_____
_____	_____

PROVIDER STATEMENT:

I certify that the information provided on this form is true and correct. I will notify Office of Medical Services Provider Enrollment of any additions/changes to the information.

Name: _____ Title: _____
(please print)

Signature: _____ Date: _____